

Data, circumstance and politics: reflections on regional mental health planning

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Abstract

We use our experience as consultants to a regional mental health planning project in South Australia to describe three practical aspects of regional health planning. First, we systematically summarised various data on socio-demographic indicators, health status and health service use along with qualitative opinion about needs and services from consultations with over 200 stakeholders. In addition to these data, we found that attention to two other aspects of planning, circumstance and politics, were of critical importance, particularly if the plan was to be implemented and as a way of turning thinking into action.

Introduction

Regional planning in health has gained impetus in recent years in Australia. Recent planning initiatives include the Commonwealth Regional Health Services Program and the Aboriginal Primary Health Care Access Program that require the identification and prioritisation of local needs for service development (National Rural Health Policy Forum 1999; Fuller et al 2001; Australian Department of Health & Ageing 2002). In this context and in the context of state and national reforms in mental health, the Northern and Far Western Regional Health Service in country South Australia engaged the Spencer Gulf Rural Health School to assist with the development of a regional mental health plan (Mental Health Branch 1999; Mental Health Services 2000). In this paper we describe the planning brief and the overt and rational data related process that we used to arrive at a plan through which 19 agencies agreed to collaborate. We then discuss the more covert circumstantial and political aspects of the planning process that we had to consider to secure this agreement.

The region in which the planning was conducted is the largest and most remote in South Australia. Two thirds of the region's 54,000 population are concentrated in only two adjacent regional cities and the remainder in eleven smaller settlements spread over 756,000 square kilometres of arid landscape (figure 1). The regional population includes the highest proportion of Aboriginal people in South Australia and there are considerable numbers of non-English speaking background immigrants, particularly in the remote opal mining settlements of Coober Pedy and Mintabee. The region has a relatively high percentage of socially disadvantaged people who would be expected to have high human service needs (Fuller and Edwards 2001).

The planning brief called for a rational articulation of needs, a listing of the current services, identification of the gaps and the determination of priorities for responding to mental disorders and other problems such as domestic violence and drug and alcohol abuse. We were to include a focus on the prevention of mental health problems and the promotion of community social and emotional wellbeing (Fuller and Edwards 2001).

This breadth made the planning process different than if the focus had been principally on mental health services as has been the case in other regions (Piscitelli 1998). Because of the large geographic area we realised early on that to be locally relevant, as well as to have an overarching plan for the whole region, the plan had to include sub-plans that were specific to the circumstance of local communities. The purpose of the plan was to improve services through better coordination. The planning scope was wide and the Regional Health Service was clear that the process had to engage all relevant stakeholders so that broad commitment to the plan was obtained. The concern of the Regional Health Service was twofold, first that there were a number of organisations providing mental health related services in the region but whose efforts and resources were not coordinated, and second, that community mental health and wellbeing went beyond the concern and responsibility of any one agency and so required collaborative organisational and community engagement.

The planning management committee

The first task was to establish a planning management committee and the first decision was who should be represented on this committee. Because of the wide planning brief representation could have been broad, drawn from the large range of mental health and generalist health and community organisations. This would have been unwieldy. We decided that there were other mechanisms to involve stakeholder organisations and community groups, such as planning forums, and so we limited the management committee to five representatives from the Regional Health Service who commissioned the plan. The committee met monthly throughout the project to review progress with decision-making by consensus in accordance with the planning brief. In hindsight, the limited composition of the planning management committee was a mistake. Given that the intent of the plan was that it be for the whole region a committee that articulated a few more views outside of the Regional Health Service would have been useful.

The planning management committee asked that we engage the stakeholders around priorities that they agreed were important and would work together on. For this reason the committee did not want a plan with detailed strategies and responsibilities already outlined, as this would seem like the plan was being imposed from the Regional Health Service. Rather, they wanted broad goals from which the participating stakeholders could develop strategy over time as the plan was rolled out.

Available data

The data that we used to identify the mental health needs, current services, gaps and priorities for the region came from four sources:

1. Demographic and social indicator data.
2. Data on regional health status and service use.
3. Data from state and national surveys.
4. Systematic consultation with key informants about which groups had unmet mental health needs and the adequacy of services.

The availability of these data varied. *Demographic and social indicator data* from the Australian Bureau of Statistics was quite complete. These data told us that in our region there were a high proportion of Aboriginal people, people under the age of 14, single parent households, unemployment and the highest level of disadvantage in the State according to the SEIFA index (Australian Bureau of Statistics 1996). We assumed that with such an index, the health needs of these high proportion population groups would be significant and we were able to locate this disadvantage to particular statistical local areas (table 1).

We then turned to the *data on regional health status and service use* to further identify specific health needs. There was only one local survey of one city in the region (Whyalla) that revealed no difference in the prevalence of adult mental disorder when compared to the state (Dal Grande et al 2000). Hospital separation data and data

on the use of various welfare services indicated some potential areas of need. For instance, we found high standardised hospital admission ratios for psychosis and neurotic conditions in some locations. Of particular note was the 56% elevation in admissions for alcoholic psychosis in the region and twice the state percentage of people in the high alcohol risk category (Nguyen 1996; South Australian Department of Human Services 2000). Data from the two community mental health teams in the region revealed that relationship and family problems were two of the high demand reasons for presentation, even though dealing with these problems is not the role of these teams (Dugan and Crismani 2000). The emergency telephone counselling service (Lifeline) also reported a high demand for counselling and relationship assistance. We found a relatively high rate of contact with the government welfare agency for homelessness, community service orders, child protection notifications and adolescent at risk assessments (South Australian Department of Human Services 2000).

There were problems, however, with these data on regional health status and service use. Small population denominators and relatively low incidence and prevalence of some problems meant that we could only make limited judgements about comparative need between locations in the region and with other regions. Furthermore other data on community health, such as from general practitioners, is not readily available. The planning management committee only wanted us to collate the data that was readily available and therefore we did not compile Medicare and Pharmaceutical Benefits data for the region. These data are not routinely published at the regional level and we considered that for the effort required it would only give us information about 'medicalised' mental health problems. We also decided not to undertake an economic analysis of the available and needed resources. The planning management committee was concerned that organisations would be reluctant to get involved in discussion about their finances and what they needed prior to having agreed in principle to collaborate on a regional approach to mental health. An economic analysis would have been a large undertaking to cost resources within the wide parameters of the planning brief. The detail from these analyses would have been useful, but not necessary to secure collaborative engagement and in some instances may have got in the way if organisations saw the plan as a way of appropriating some of their resources. Compiling such data could come later as the stakeholders started to get into the detail of working together on particular goals under the plan.

In light of these limitations in the regional data, we also used data from *studies conducted at the national and state levels* to make assumptions about likely mental health needs in the region. Hospital data revealed a lower than expected admission ratio for psychosis amongst South Australian country residents and a higher than expected admission ratio for neurotic and other mental disorders (Glover and Tennant 1999). Admission rates for all mental disorders has been found to be four times higher for Aboriginal people in the country than for non Aboriginal people (Nguyen et al 1996). National data on suicide revealed a higher rate amongst males in rural and remote areas (Australian Institute of Health and Welfare 1998). Rates are particularly high among males aged 25-44 and is increasing most rapidly amongst young males aged 15-24 (Commonwealth Department of Health & Aged Care 2000). The use of alcohol and drugs and also unemployment are thought to be associated factors. Using this state and national data we could assume that needs would be particularly important for Aboriginal people and for males.

Taking into account the three sources of data, we concluded that the region had high mental health needs related to children and youth, males, Aboriginal communities, alcohol problems, non psychotic mental disorder and generalist counselling. This available demographic and epidemiological data described need that had been measured, and to ensure a more complete picture we *systematically consulted with a range of key informants*. This provided qualitative perceptual data about unmet mental health needs and the adequacy of services.

Consultation

We had to decide how wide to consult. On the one hand we wanted to be inclusive, but for pragmatic reasons we had to put some boundaries on this, otherwise the consultation would have been too large and unmanageable. Our loose criterion was to bind the consultation to those groups who could readily engage with the Regional Health Service in the first three years of the mental health plan.

The consultations were conducted in three rounds over 18-months through a process similar to a Delphi technique (Jones and Hunter 1995). A summary of the available data was provided in the first round and the results of previous consultations were fed back to informants for refinement in subsequent consultations. The processes included individual interviews, group meetings and larger forums in most of the locations in the region. Informants were a range of over 200 service providers and managers of mental health, generalist health and human service organisations (including police, ambulance, education, housing and local government) and community members who belonged to mental health related groups. These included Indigenous and non-Indigenous informants.

Aside from views about mental health needs, the first round of consultations revealed various system problems that included the following:

- Clients falling through service gaps when they did not meet any organisation's core business criteria. In this region this meant gaps for people who needed generalist counselling.
- Boundary arguments between general practitioners, community mental health teams, drug & alcohol services and Aboriginal health services about who was the client's primary care organisation.
- Visiting psychiatrists used mainly for casework, rather than as case consultants for local workers or for training.
- A high turnover of workers in the community mental health teams which made it difficult to establish longer-term effective collaboration with other organisations.

We wrote up the issues about perceived needs and adequacy of services into a report that included a summary of the demographic and epidemiological data and this was sent to all the informants' organisations and community groups. This report was used as the basis for the second round of consultations that resulted in a prioritised list of eleven service-related issues and seven high need population groups. We then used this consultation data with the other data described above to draft a regional mental health plan that we sent out for feedback during a third consultation round. We initially wanted to include in the draft plan detailed strategies and organisational responsibilities, but we soon recognised that too much detail and allocation of responsibilities at this 'birthing' stage of the plan would make it difficult to secure planning agreement from organisations. Feedback was specifically sought from the chief executive officers of the main stakeholder organisations, because we wanted them to sign off on the plan. Group feedback was used when we wanted discussion between specific organisations on a particular issue, such as between the drug and alcohol service and the mental health teams about client referrals.

The systematic process of working through the data to arrive at a plan was the outward logic that drove our rational decision-making. We found that this systematic analysis of the data was not, however, enough to arrive at effective decision making about what the plan should look like or how it might operate. Circumstantial factors in the environment and politics between the stakeholders had to be taken into account.

Circumstantial factors

The consultation process was not straightforward and we had to take into account circumstantial factors in the environment. For instance, the development of this regional plan occurred at the same time that centrally driven reforms were occurring to mental health services in the state (Mental Health Services 2000). These state reforms would obviously impact on the regional plan, and there was some criticism about moving ahead with this regional process before the state reforms were fully known. These unknowns meant that as planners we had to accept some incremental muddling though as we worked out the directions of the state reforms and how these could inform the regional plan.

We also had to be flexible to account for unknown factors within the region. For instance, when first setting up the consultations we were not absolutely clear about who should be consulted. As we proceeded we became more aware of the relevant organisations and groups and the key and motivated individuals around mental

health. Our engagement with people helped to identify points of support (key motivated individuals) and points of resistance. The group meetings in the second round consultations helped identify who was interested in mental health work, what they wanted to work on and who else should be approached on particular issues. Yet, we discovered important groups late in the process. In one town we only discovered the existence of a town social development committee after we had already called a special town meeting and in the subsequent consultation round we made sure that we went through this committee.

Political factors

In the face of high demand for human services, many of the organisations with whom we consulted defined quite specifically their ownership of problems, or in other words, what was their core business. For mental health teams this was a client with a major psychiatric diagnosis. For the government welfare service this was child protection. With other organisations, such as police and local government, anything labelled as health was not core business. This caused some tension at the service delivery level (horizontal tension) when a person's problem did not clearly sit within one organisation's core business. A stark example was in one town that we visited where all of the workers in the store (a major employer) appeared to be non-Aboriginal, but most of the customers were Aboriginal. The link between unemployment, purpose and self-esteem would be a significant determinant of mental health amongst Aboriginal people in that town and so dealing with mental health simply as a clinical issue would be short sighted. Dealing with such problems from a community perspective could be a shared responsibility between the Aboriginal community bodies, local business, Aboriginal health services, mental health services, mainstream generalist health services and others.

Joint ownership of problems could help to overcome the problem that we found in a town where the community health nurse organised a mothers group but then had very few mothers attend. Joint ownership could mean the Health Service provides the community health nurse with health knowledge and the Aboriginal Community Association provides an Aboriginal community worker who encourages young mothers to attend.

We found that differences in how system problems were understood were influenced by an organisation's mode of operation. For instance, general practitioners predominantly saw clients in clinical encounters and so they wanted easier referrals to the community mental health teams. The regional health bureaucrats wanted to increase health promotion, so they wanted the community mental health teams to take on more mental health promotion and not only see clients. This meant that the same issue of how many clients should be seen was considered differently. At present the community mental health teams are not able to operate in a way that pleased both. To deal with this we have proposed under the plan that agreements be developed so that organisations have an understanding about each other's role and responsibilities. Another concern that appeared to make it difficult for organisations to come openly to the planning table were the different sources and level of funding between general practitioners, Aboriginal health services, mainstream government health services and non-government organisations. Each articulated views about the resources and hence responsibility that others had for dealing with unresolved servicing problems.

In addition to ownership of problems amongst local organisations, we also found servicing concerns between local, regional and statewide organisations (vertical tension). This appeared to be exacerbated by the concomitant development of a regional and a state plan for mental health. We found concern from local stakeholders of an imposed state and regional agenda and some suspicion on their part about getting involved, particularly if this meant devolved responsibility without increased resources or support. For instance, the Regional Health Service wanted local communities to be involved with them in sharing resources and in responding to local social health issues. Their rationale was that local human service workers can provide a local responsiveness to needs and they can coordinate services on the ground. However, local workers requested that if they were to do this then the Regional Health Service, the mental health teams and statewide organisations, such as drug and alcohol services, should contribute staff expertise and training. On the other hand, statewide organisations expressed concern that devolved responsibility might mean that specialist field staff would lose the support that they received from being employed in a larger and centrally administered specialist

organisation. These concerns led to some initial resistance from both local and statewide stakeholders about the regional plan.

We identified the following four strategies to promote greater joint ownership of problems:

- (1). Our consultations revealed the key motivated individuals who had a vision about what was possible and we focussed our planning work with them. Once these key individuals were 'on-board', then in time we considered that others would see what was possible.
- (2). A series of regional task groups, such as to deal with counselling issues, drug & alcohol problems etc, that would give a program focus in addition to the current service focus. These task groups would engage relevant individuals in a learning and change process through their group involvement, where they had to think about problems from a region wide and inter-organisational perspective.
- (3). More formal learning (workshops) for staff that would be conducted jointly across human service sectors (hospitals, police etc). This would challenge staff to think about their respective and linked roles in improving the mental health service system.
- (4). The establishment of mental health reference groups in various locations in the region. Membership of these reference groups would come from relevant local organisations to deal with local issues as well as be a forum for skills development. Members could include the local GP, community nurse, visiting mental health worker, police, and teacher.

In these local and regional task groups our intent was to create networks as a matrix structure through which the stakeholders could collaborate and be responsive to local and regional problems, whilst retaining the professional and resource benefits of employment through their own organisation. Fleury et al (2002) found in Canada, that network structures were suited to the completion of complex operations without losing benefit of small-scale interventions adapted to local needs. In the small population locations of the Northern and Far Western Health region we considered that collaboration through networks was an appropriate structure through which to bring the expertise and efficiency of large organisations to be responsive to the complexity of dealing with mental health at the local level. A regional program manager in mental health has since been appointed who has the responsibility to oversee the implementation of the plan.

Discussion

Our involvement as consultants in this planning process led us to reflect on a number of issues related to the nature of community health planning. The first of these was about the breadth of focus in the first cycle of a regional plan. While some literature suggests that broad-brushed planning does not lead to focussed change (Hawe 1996; Fuller et al 2001), we were given a broad planning brief. As this plan was in its first and formative cycle (with a relatively unknown field), we decided that a broad exploratory approach was warranted before delineating a more focussed approach in subsequent cycles. Our thinking in relation to the planning focus followed Mintzberg's (2000) point that umbrella strategies are best at first to provide the broad and deliberate outline and that the details of particular strategies can emerge dynamically over time. Too much detail at the start would have meant laborious negotiation to secure inter-organisational agreement and then a resistance to change these agreements as circumstances changed.

Our second issue was about the recognition of planning as a circumstantial process. We came to understand this as a response to those aspects in the environment that could not have been known at the outset or that changed during the planning period. For instance, we faced an uncertain planning field with the concomitant development of a state plan, and the Regional Health Service was criticised for 'pre-emptively' proceeding with their own plan in the face of this uncertainty. We responded to this criticism by rationalising that planning cycles between levels of organisation are often not compatible. Because the health system is in constant change, it could have been a long wait for the complete and stable state plan. Furthermore, with its own plan, the region would be well placed to grasp early opportunities that might come out of the state plan.

Our third issue was to reflect on the political nature of planning. We came to understand this as the factors that effect the relationships between organisations and so their ability to work together. We experienced three political factors as (1) the ownership of problems (horizontal tension), (2) the different modes of organisational operation, and (3) the different levels of responsibility (vertical tension). We acknowledge that heavy workloads caused organisations to think about themselves in a focussed way and we recognised that they were best to focus on what they did best. However, this should not mean ignoring other issues. We wanted organisations to take a system wide view about their role and about their links to other organisations. For example, a response to youth drug use would be of interest to police, and their policing role could be one strategy in a community program that also involved health organisations. For organisations to work beyond their core business boundaries staff need to think more broadly about their role. To change could be a threat to the way that staff constructed their work in response to high service demand. In a regionally collaborative approach, however, the Regional Health Service, the mental health teams and others have a responsibility to support local mental health servicing to take advantage of a larger and more sustainable specialist resource base. This means that there is a nexus of vertical responsibilities, where each level has to both give and take. In particular, the centre (Regional Health Service head office) cannot expect the periphery (local communities) to do more without resources. There can be tension between these levels of planning whenever a plan seeks to be locally responsive but also sustainable by tapping into regional and statewide resources. Rather than avoid this tension, what is required is that it be negotiated in what Charles Handy referred to as the exhaustive management task of balancing local autonomy with the common purpose of the whole organisation (Handy 1996).

Our experience of these political factors required that we try to understand the different concerns and motivations of organisations and groups. One example of this concern was the criticism of inadequate local servicing that a mental health team felt they would face from their home town if they spread their activities to also service other communities. These different concerns and motivations were not always obvious to us as we engaged in our planning process. We learnt early on to simply be aware that these differences would exist and to understand that they would cause organisations to put up certain objections about moving forward. It was useful for us to understand and accept these objections and to work through them rather than reject them out of hand and thereby cause greater resistance. We also learnt, however, not to get held up by particular objections and to keep the planning process moving forward.

Reflection on these issues helped us to understand more about the purpose and nature of planning. Our experience through this project is that effective planning is a messy process in which the rational use of data must be considered along with the contingent nature of circumstance and the politics of conflict. This experience, along with our reading of the literature led us to conclude the following five points (Hassett and Austin 1997; Hodge and Howenstine 1997; Dant and Francis 1998; Mintzberg 2000; Eagar et al 2001; Fleury et al 2002, 2003):

1. One role of the planner is to bring technical knowledge and tools of rational inquiry to bear on problems of policy implementation and decision-making (identifying goals, proposing lines of action, estimating consequences).
2. Uncertainty in the future means that even when agreement is reached and a plan formulated, strategies will have to be modified over time. Circumstances change constantly, and all the issues and opportunities cannot be known at the outset.
3. In human services a political dimension is inherent in planning at all levels. This is because; (a) plans are always dependent on decisions made by other organisations, and (b) courses of action are always tied up with the interests of individuals and the orientation of organisations, which are to pursue those activities that sustain their existence.
4. Planning is involved when people come together for the purpose of previewing a task and coordinating their activities. This means that conflict is endemic in planning and this inevitably leads to compromise.
5. The plan could be seen as an interface between thinking and action.

Conclusion

In this paper we have described our use of data, as well as the circumstantial and political aspects of a regional mental health planning process. Data from four sources comprised the raw material from which we planned. Some data provided quite complete social demographic indicators at the level of a statistical local area. Regional data on health status was not as useful, as low population denominators in small rural areas, combined with low prevalence of some mental health problems, limited our ability to establish comparative need between locations or with other regions. In addition there were gaps, as local data were not readily available from general practitioners who are the main providers of health services in communities. We dealt with these limitations by drawing assumptions about local need from respective state and national studies. Our main planning activity was to use a series of stakeholder consultations that added qualitative data about need. These consultations also provided a process through which to engage with organisations and community groups on the prioritisation of service related issues and high need population groups.

Our experience taught us that planning is not simply about the rational analysis of data, as if the solutions to problems lie in a better use of information. Rather, we found that a focus was also required upon the engagement of those people and organisations that could make a difference. This engagement was important to ensure that the plan became the means of getting things to happen. Engagement required attention to circumstantial and political processes, such as the resistance to joint ownership of problems when organisations confined their work to a narrow definition of core business. Circumstance and politics means that planning can get 'messy', where flexibility and responsiveness are required to deal with the tension of interests between local, regional and statewide organisations. We suggest that these tensions be regarded as the normal process of negotiating agreement, but we recognise that this negotiation does take time and can be exhausting.

Attention to these fluid aspects of planning are important, where circumstances constantly change and players continually bring their agenda to the planning table, and so we suggest that better planning is not simply the product of more and better data, but also responsiveness to circumstance and politics.

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Fig 1: The Northern & Far Western Health Region of South Australia



Table 1: Social indicators by statistical local area: Northern & Far Western Health Region (percentage of population)

STATISTICAL LOCAL AREA	0-14	born NESB	ATSI	couple with dependant children	1 parent families	Un-employment
Whyalla (C)	24.2	7.6	2.3	39.4	12.5	14.2
Unincorp Whyalla	19.6	4.7	5.2	26.1	14.1	20.5
Hawker (C)	23.3	1.6	7.1	51.4	3.7	6.2
Kanyaka-Quorn (DC)	25.8	2.1	7	42.9	5.7	11.4
Pt Augusta (C)	24.8	3.4	13.8	40.1	12.4	14.5
Unincorp Flinders Ranges	27.9	2.5	14.5	54.7	3.8	5.9
Coober Pedy(DC)	23.2	28.8	18.6	41.8	10.1	19.6
Roxby Downs (M)	30.2	3	1.6	65.4	1.8	3.5
Unincorp Far North	29.7	4.9	47.6	49.5	10.2	7.2

Source: ABS social & housing characteristics for SLAs SA 2015.4 1996